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No. .....

Supreme Court, U.S.
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In The
# Supreme Court of the United States
October Term, 1985

GINA DUNNING, Director of the Nebraska Department of Public Welfare; KAY C. ORR, Treasurer of the State of Nebraska; CLIFTON A. SEXTON, JR., Director of Administrative Services,

*Petitioners,*

vs.

THE NEBRASKA HEALTH CARE ASSOCIATION, INC., A Nebraska Nonprofit Corporation; THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOCIETY, A North Dakota Nonprofit Corporation; W.S.T. CARE, INC., d/b/a CRESTVIEW CARE CENTER, a Nebraska Corporation,

*Respondents.*

## PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

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## QUESTIONS PRESENTED FOR REVIEW

1. Whether a challenge to the operation of a state Medicaid plan under Title XIX of the Social Security Act brought by providers of services who are under contract with the state Medicaid agency can properly be brought under the provisions of 42 U.S.C. § 1983 and properly include an award of attorney fees pursuant to 42 U.S.C. § 1988.

2. Whether the federal approval of a state Medicaid (Title XIX) plan amendment which contained a limitation on provider reimbursement rate increases imposed by state statute is entitled to deference by the federal courts when reviewing the reasonableness of such limitation.

## PARTIES

The parties are:

Petitioners:

GINA DUNNING, Director of the Nebraska Department of Public Welfare;

KAY C. ORR, Treasurer of the State of Nebraska;

CLIFTON A. SEXTON, JR., Director of Administrative Services.

Respondents:

THE NEBRASKA HEALTH CARE ASSOCIATION, INC., A Nebraska Nonprofit Corporation;

THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOCIETY, A North Dakota Nonprofit Corporation;

W.S.T. CARE, INC., d/b/a CRESTVIEW CARE CENTER, a Nebraska Corporation.

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## CITATIONS TO THE OPINIONS BELOW

The opinion of the District Court for the District of Nebraska, No. CV82-L-472, filed July 9, 1984) and the opinion of the Court of Appeals, for the Eighth Circuit, filed December 9, 1985, reported at 778 F.2d 1291 (8th Cir. 1985), appear as Appendix A. The supplementary opinions rendered by the District Court and the Court of Appeals appear as Appendix B. Neb.Rev.Stat. § 68-720 (Cum. Supp. 1983). The statute challenged by petitioners appears as Appendix C.

## JURISDICTION

The judgment of the Court of Appeals for the Eighth Circuit was entered on December 9, 1985. The plaintiff's petition for rehearing was denied on February 25, 1986, and this petition for certiorari was filed within ninety (90) days of that date. This Court's jurisdiction is invoked pursuant to 28 U.S.C. § 1254(1).

## CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

1. Article VI, Constitution of the United States
2. Amendments Five and Fourteen, Constitution of the United States

3.

42 U.S.C. § 1396a(a)(13)(A)(Supp. 1985)

42 U.S.C. § 1983

42 U.S.C. § 1988

Neb.Rev.Stat. § 68-720 (1983 Supp.)

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## STATEMENT OF THE CASE

The respondent, Nebraska Health Care Association, brought this action in the United States District Court for the District of Nebraska challenging the constitutionality of two statutes, Neb.Rev.Stat. Section 68-720 (Appendix C. App. 44) and § 68-721, (Cum. Supp. 1982) and pursuant regulations.

Section 68-720, the first statute to which plaintiffs objected, imposed a 3.75% limitation on the increase of Medicaid reimbursement rates for long-term care facilities. The limitation was based on those rates in force on April 1, 1982. The second statue challenged by plaintiffs, § 68-721, provided for a pro-rata reduction of rates for long-term care facilities to be determined by the Director of the Nebraska Department of Social Services in the event of a shortfall of funds. Section 68-721 was enjoined from implementation by the District Court through a preliminary injunction. The plaintiff's challenge of § 68-721 was not appealed to the Eighth Circuit Court of Appeals and is not an issue in the petition.

This action was originally filed by plaintiffs on August 30, 1982, under the provision of 28 U.S.C. § 1331(a) as to the State defendants. Other statutes were cited by plaintiffs to include the federal defendants who were subsequently dismissed from the action following their Motion for Summary Judgment. Later, on May 19, 1983, after the case had progressed for approximately nine months the plaintiffs on July 19, 1983, requested leave to amend their complaint to allege a 42 U.S.C. § 1983 cause of action, which motion was ultimately allowed by the United States District Court for the District of Nebraska in its entirety.

On July 9, 1984, Judge Warren Urbom of the United States District Court for the District of Nebraska declared both § 68-720 and § 68-721 to be unconstitutional (Appendix A. App. 21). With respect to § 68-720, the statute in issue here, Judge Urbom indicated in his Memorandum and Order that he considered the 3.75% inflationary lid to be in conflict with 42 U.S.C. § 1396(a) (13) (A). His rationale was, in part, based on the extent of studies or lack thereof made by the Department of Social Services as to the lid's impact on Medicaid providers and his determination that some of the providers were adversely affected by the inflationary limitation. The Nebraska Department of Social Services' position was that there had been adequate in-house studies, the resulting rate was within a "zone of reasonableness", and the approval of the plan with the limitation was entitled to deference.

The State defendants appealed to the Eighth Circuit Court of Appeals which entered an opinion on December 9, 1985, affirming the decision of the District Court as to

the applicability of § 68-720 for fiscal year 1982-1983, but holding that consideration of its effect as to fiscal year 1983-1984 was premature and not ripe for judicial determination (Appendix A. App. 22). The District Court's approval of attorney fees under § 1988 was also affirmed by the Circuit Court. The Association's rehearing filed by plaintiffs was overruled on February 25, 1986 (Appendix B. App. 43).

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## REASONS FOR GRANTING THE WRIT

### I. The Decision Below Raises An Important Question of Federal Law Which Has Not Been, But Should Be Settled By This Court; And The Decision Below Conflicts With Decisions, On A Federal Question, Of Other Federal Courts On The Same Matter.

The Eighth Circuit Court of Appeals in this case has rendered a decision on a federal question directly in conflict with the decisions of other federal courts as to the issue of whether long-term care facilities and other Medicaid providers are proper plaintiffs in a 42 U.S.C. § 1983 cause of action. In the original complaint, plaintiffs alleged that jurisdiction was established under 28 U.S.C. section 1331(a). Later, after the case had progressed for approximately nine months, the plaintiffs requested leave to amend their complaint to allege a section 1983 cause of action on the basis that the implementation of regulations pursuant to the Nebraska reimbursement statute would deprive the Medicaid providers of their rights under the Supremacy clause of the United States Constitution.

The defendants filed a 12(b)(1) Motion to Dismiss contending that plaintiffs could not obtain jurisdiction under 42 U.S.C. § 1983. The United States District Court for the District of Nebraska originally ruled favorably for the State, denying plaintiffs Motion for Leave to File a Supplemental Complaint (Appendix B. App. 36). The complainants subsequently filed a Motion for Reconsideration citing *Maine v. Thiboutot*, 448 U.S. 1, 100 S.Ct. 2502 (1980) in support of their claim that jurisdiction under § 1983 was proper to secure compliance with the Social Security Act.

The District Court subsequently reversed its earlier ruling citing *Maine v. Thiboutot, supra,* as the basis for its change of position (Appendix B. App. 38). After the District Court ruled favorably for the plaintiffs on the merits, the court authorized an award of attorney fees pursuant to section 1988. The Eighth Circuit Court of Appeals quoted the language of the District Court stating:

> . . . suits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act by participating states, *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980); *Blue v. Craig*, 505 F.2d 830, 832-33 (4th Cir. 1974), including suits by Medicaid service providers to challenge the wrongful administration of a Medicaid program by a state. *Yapalater v. Bates*, 494 F.Supp. 1349, 1357-58 (S.D.N.Y. 1980). *aff'd*, 644 F.2d 131 (2d Cir. 1981), *cert. denied*, 455 U.S. 908 (1982).

(Appendix A. App. 31).

The Court of Appeals affirmed the District Court on this issue holding that Medicaid providers were proper plaintiffs to bring a § 1983 suit:

> . . . The Social Security Act, including the Boren Amendment, is a "law" within the meaning of 42 U.S.C. § 1983, which creates a right of action for people who, under color of any state law, are deprived of a right secured "by the Constitution *and laws*" of the United States. "[T]he plain language of the Statute undoubtedly embraces [plaintiffs] claim that [defendants] violated the Social Security Act." 448 U.S. at 4.
>
> The state seeks to distinguish *Thiboutot* on the ground that the plaintiffs in that case were arguably being deprived of minimal subsistence and support. Thus, the argument runs, the claim of violation of the Social Security Act in *Thiboutot* is more akin to those civil-rights statutes and constitutional provisions that have always concededly come within § 1983. We cannot agree with this distinction. It has some appeal, at least as a legislative matter, but the words of § 1983 as explicitly interpreted by the Supreme Court in *Thiboutot* are clear, and, in addition, we cannot believe that Congress, without saying so, intended for the existence *vel non* of a right of action under § 1983 to depend on the wealth of the plaintiff. Moreover, the right of the long-term care institutions in this case to reimbursement under the Act could very well affect the level of care and treatment received by patients, some of whom are undoubtedly in just as much need as th plaintiffs in *Thiboutot.*

(Appendix A. App. 31).

Petitioners have never argued, however, that a plaintiff's wealth determined the appropriateness of a § 1983 cause of action. Rather, petitioners submit that plaintiffs in the instant case were not deprived of any rights secured "by the Constitution [or] laws" of the United States since plaintiffs are not intended beneficiaries of the Medicaid program.

The standards for § 1983 cognizability as interpreted by the United States District Court for the State of Nebraska and other federal courts are in conflict. The District Court and the Eighth Circuit Court of Appeals relied upon *Yapalater v. Bates,* 494 F.Supp. 1349 (S.D.N.Y. 1980), *aff'd,* 644 F.2d 131 (2d Cir. 1981), *cert. denied,* 455 U.S. 908 (1982) to support their view that § 1983 encompasses claims of Medicaid providers. In *Yapalater,* a private psychiatrist sued New York State officials due to their failure to approve Medicaid reimbursement for services of personnel working under the psychiatrist's direction. The United States District Court for the Southern District of New York upheld the provider's § 1983 claim stating that "the state has deprived him of Medicaid reimbursement to which he is legally entitled. He has, therefore, 'been injured by the administration' of a federal-state cooperation program." *Yapalater v. Bates, supra,* 494 F.Supp. at 1358. Defendants are aware of no other cases, however, which adopt the *Yapalater* rationale.

In cases factually similar to the one at bar, other federal courts have arrived at conclusions opposite to those of the *Yapalater* court and the Eighth Circuit Court of Appeals in the instant case. For example, in *Grossman v. Axelrod,* 466 F.Supp. 770, 646 F.2d 768 (1981), the Second Circuit Court of Appeals held that "under New York law, Medicaid providers have no property right in prospective reimbursement payments." 646 F.2d at 771. In citing an earlier case, *Greenwald v. Whalen,* 609 F.2d 665, (2d Cir. 1979) the Circuit Court noted that "New York State law 'creates substantial doubt as to whether

a nursing home has a protectible interest in a particular rate of reimbursement'." In a subsequent case the Second Circuit again denied relief to a health care provider who brought a § 1983 action alleging that its Medicaid reimbursement rate was reduced without due process. After determining that Medicaid providers have no property interest in future reimbursements, the Circuit Court dismissed the nursing home's claim. *Oberlander v. Perales,* 740 F.2d 116 (2d Cir. 1984).

The United States District Court for the Southern District of Texas also had occasion to address this issue when hospital Medicaid providers brought suit under § 1983 alleging that their civil rights and right to due process were violated when the Texas Department of Human Resources attempted to recoup overpayments made to the providers. *St. Joseph Hospital v. Electronics Data Systems,* 573 F.Supp. 443 (S.D. Texas 1983). The Texas federal court in *St. Joseph* dismissed the plaintiffs' § 1983 claim noting that:

> Procedural due process is not invoked by every governmental action which adversely affects private interest, rather, due process safeguards apply only when a person is deprived of life, liberty or property without due process of law . . . [W]e are convinced that the hospitals have no vested property interest in retaining the spell of illness overpayments.

Id. at 447. In reaching this conclusion, the *St. Joseph* court relied upon the Tenth Circuit Court opinion in *Geriatrics, Inc., v. Harris,* 640 F.2d 262 (10th Cir. 1981), U.S. *cert. denied,* 454 U.S. 832 (1981) wherein the Eventide Nursing Home argued it had been denied due process after the home was terminated from the Medicaid pro-

gram. In discussing what protectible property interest the home possessed, the Tenth Court of Appeals noted:

> Eventide is not the intended beneficiary of the Medicaid program. Instead, the purpose underlying the funding program is to extend financial benefits to the patients eligible to receive their medical care at government expense. 42 U.S.C. § 1395a. Eventide argues also that termination of benefits would force the Home to close and it therefore, has a significant financial interest to retain its certification. The Home's financial need for government assisted patients is incidental to the purpose and design of the program. Eventide's operating license has not been rescinded and it may still operate as a nursing home and render care to private day patients. The unfortunate reality that it will probably encounter difficulty operating at capacity is not of constitutional significance.

*Id.* at 265.

In *Arden House, Inc. v. Heintz,* 612 F. Supp. 81 (D.C. Conn. 1985), the United Statees District Court for the District of Connecticut recently held that long-term care facilities were not the intended beneficiaries of the Medicaid program and, thus, had no cause of action under section 1983, in direct contravention to the decisions reached by the Nebraska District Court and the Eighth Circuit Court of Appeals. In *Arden House,* a long-term care facility challenged the Connecticut reimbursement system for skilled nursing facilities as violative of state law and the federal Medicaid Act. The complaint alleged that the prospective reimbursement rate set by the State did not reimburse the plaintiff for "reasonable" costs incurred. After referring to *Maine v. Thiboutot, supra,* the District Court for the District of Connecticut acknowledged that

§ 1983 encompasses violations of federal statutory law, including the Social Security Act. The District Court then cited *St. Joseph Hospital v. Electronic Data System*, supra, and set out the elements of a valid § 1983 claim:

> (1) Whether the conduct complained of was committed by a person acting under color of state law and (2) whether the conduct deprived the plaintiff of a right secured by the United States Constitution or laws.

*Arden House, Inc. v. Heintz, supra,* at 84. The District Court emphasized that in addition to demonstrating injury it was necessary for the claimant to show that it was *an intended beneficiary* of the Medicaid program. See, *Balf, Co., Inc. v. Gaitor,* 534 F.Supp 600, 604 (D. Conn. 1982). The District Court found that the nursing home in *Arden House* was not an intended beneficiary of the Medicaid program, and moreover, had no "protectible interest in a particular rate of reimbursement." *Arden House, Inc. v. Heintz, supra,* at 84, citing *Grossman v. Axelrod, supra,* at 771.

Petitioners would submit that the decision rendered by the Eighth Circuit Court of Appeals in this case is in direct conflict with the opinions reached by other federal courts on the issue of whether Medicaid providers are proper plaintiffs in a § 1983 cause of action. We therefore submit that in the wake of *Thiboutot* there have been a number of federal court decisions that are in obvious and irreconcilable conflict. *Thiboutot* was a case involving a recipient or beneficiary under the Social Security Act. The conflict stems from cases involving providers or contractors with agencies administering programs under the

Social Security Act. It is now imperative that this Court settle this conflict and that may be accomplished through a review of this case.

**II. The Decision Below Conflicts With The Decisions, On A Federal Question, Of Other Federal Courts On The Same Matter.**

The Eighth Circuit Court of Appeals in this case has rendered a decision on a federal question directly in conflict with the decisions of other federal courts. In affirming the decision of the District Court, the Eighth Circuit held the Nebraska reimbursement statute to be unconstitutional under the Supremacy clause. Petitioners submit that this ruling is in conflict with *Gould v. Wisconsin Department of Industry, Labor and Human Relations,* 576 F.Supp. 1290, 750 F.2d 608 (7th Cir. 1984), U.S. *app. pndg.* 106 S.Ct 305 (1985) which held that a corporation that prevailed on allegations that State statutes were preempted by federal labor law but failed to establish that the statutes violated its Fourteenth Amendment Rights was not entitled to recover attorney fees under section 42 U.S.C. § 1988.

Although *Gould* involved preemption by federal law rather than a violation or inconsistency of federal law, the Supremacy theme is common to both. In the instant case, the Eighth Circuit Court cited *Maine v. Thiboutot, supra,* in reaching its decision and dismissed the appellant's argument that the claim in *Thiboutot* was more akin to those civil rights statutes and constitutional provisions that have always concededly come within § 1983. Basically, the State argued that the action of 176 Nursing Homes

operating under provider contracts challenging a reimbursement plan could not claim the denial of fundamental rights to bring their cause under § 1983. The State took this position in opposition to a Motion for Leave to Amend the Complaint to include a § 1983 allegation. Thus, the State argued that *Thiboutot* did not apply in the claim for attorney fees in this case.

In rejecting the State's position in this matter, the Eighth Circuit is in conflict with *Gould v. Wisconsin, supra.* In *Gould* the court stated:

> *Thiboutot,* while expanding the reach of 42 U.S.C. § 1983 held only that statutory claims raised under § 1983 were proper claims for which attorney fees under 42 U.S.C. § 1988 would be available. The case did not address the issue whether claims based on the Supremacy clause would be cognizable under § 1983.

*Gould v. Wisconsin, supra,* at 616. In *Gould,* the Seventh Circuit Court stated that in other cases this Court has recognized that not all statutes secure rights within the meaning of section 1983. *Middlesex County v. Sewage Authority v. National Sea Clammers Association,* 453 U.S. 1, 19, 101 S.Ct. 2615, 2625, (1980) *Pennhurst State School and Hospital v. Haldeman,* 451 U.S. 1, 28, 101 S.Ct. 1531, 1545, (1980). Furthermore, in *Gould* the Seventh Circuit pointed out that § 1983 was enacted to override discriminatory state laws, provide a remedy where state law was inadequate, and furnish a federal remedy where the state remedy, although adequate in theory, was not available in practice. *Monroe v. Pape,* 365 U.S. 167, 81 S.Ct. 473, (1961).

It should also be noted that in *Gould* the Seventh Circuit Court alluded to the impingement of individual rights

as being a determining factor in the cognizability of a § 1983 claim. In its comments concerning this issue, the Eighth Circuit in *Consolidated Freightways Corporation of Delaware v. Kassil,* 730 F.2d 1139, 1146 (8th Cir. 1984) also stated:

> Although the scope of § 1983 has been expanded by the *Thiboutot* decision, the Supreme Court's holding that § 1983 provides a cause of action under the Social Security Act does not represent an expansion into areas unrelated to the interests protected by the Fourteenth Amendment.

*Id.* at 1146.

Thus, the Eighth Circuit in the instant case would be in conflict with its earlier decision in *Consolidated Freightways* because in the case at bar such an expansion was made. In referring to the possible effect which the state's reimbursement program might have on the rights of individual Medicaid recipients, the Eighth Circuit Court has not recognized the realities of the market place which embodies an ongoing conflict between the interests of corporate health care and necessary cost containment efforts. In essence, the Circuit Court is attaching a "fundamental right" label to an action which basically involves an industry resisting regulation and cost control of Medicaid services.

The opinion of the Seventh Circuit Court in *Gould* and the opinion reached by the Eighth Circuit Court in the instant case are, therefore, in conflict since the Eighth Circuit has, in effect, expanded into areas unrelated to the interests protected by the Fourteenth Amendment. Although *Gould* involved preemption of state regulation by federal laws the court held that a violation of the

Supremacy clause did not in itself create an action cognizable under §1983 which would authorize attorney fees under §1988. As in *Gould,* the respondents in this case have not shown a substantial violation of either due process or equal protection under the Fourteenth Amendment.

In the instant case, both the District Court and the Eighth Circuit based the §1983 and §1988 portions of their decisions on *Thiboutot, supra,* which held that "the §1983 remedy broadly encompasses violations of federal statutory as well as constitutional law." Admittedly, the cause of action and the decision in the instant case involves an alleged violation of federal law. It is true that some courts broadly interpret the *Thiboutot* language to mean that §1983 encompasses all federal statutes. In its Memorandum and Order the District Court for the State of Nebraska relied upon *Thiboutot* and in addition cited *Blue v. Craig,* 505 F.2d 830, (4th Cir. 1974) which held that a state statute or regulation which is inconsistent with federal law poses a constitutional issue under the Supremacy clause jurisdictionally cognizable under §1343(3), if the allegations set forth at least a colorable claim of denial of equal protection. The court also cited *Yapalater v. Bates, supra,* a case involving an individual Medicaid provider who was denied recovery on the merits but was permitted to assert his claim under §1983 following the court's reasoning that he was a "recipient" of the medicaid program, to the extent he was a "recipient of reimbursement". *Yapalater v. Bates, supra,* at 1358.

Petitioners submit that the reasoning of *Yapalater* which described providers as "recipients" ignores the traditional distinction between a "provider" and a "bene-

ficiary" of a categorical benefit program and, therefore, is in conflict with other cases cited in this petition such as *Arden House, supra.*

Noting that all federal rights, whether created by treaty, statute, or regulation, are secured by the Supremacy clause, petitioner submits that there are factors to consider beyond categorizing such claims as including (1) claims where there has been a federal statutory violation cognizable under §§1983 and 1988 and (2) claims based upon preemption due to a conflict between federal and state power or authority which is not cognizable under §§1983 or 1988. The key question is whether there has been an impingement or a denial of a fundamental right. The factors to be considered in reaching that question involve the nature or status or the respondents in relationship to the petitioners and the nature of the conflict that led to the litigation.

Rather than the action being one brought by a recipient or a class of recipients, this action was brought by a health care association made up of corporate providers who regularly enter into agreements with the state to provide services. In a case such as this, it is necessary to note that the relationship between provider and client, although hopefully tempered with concern and compassion, is still one of business versus customer. This action concerns claims of the various businesses in the process of resisting cost containment efforts enacted by the Nebraska Legislature and implemented by the Nebraska Department of Social Services. When this action is considered under the Supremacy clause, it could just as easily be designated as a conflict with federal goals or power (the effect of L.B. 720 on the goals of 42 U.S.C. 1396) just as accurately

as it could be designated as an alleged Social Security Act violation. Furthermore, in support of *Gould,* language from *White Mountain Apache Tribe v. Williams,* 778 F.2d 1332 (9th Cir. 1985) is appropriate:

> We thus come down on the side of the weight of authority that preemption of state law under the Supremacy clause — at least if based on federal occupation of the field or *conflict with federal goals* — will not support an action under § 1983, and will not, therefore, support a claim of attorney fees under § 1988. (Emphasis supplied)

*Id.* at 1338.

Petitioners have pointed out that the holdings in *Gould* and the instant case are in conflict. It is also well to point out the conflict of rationale in arriving at the different decisions. In the process of rejecting the plaintiff's reliance on *Maine v. Thiboutot, supra,* and *Inada v. Sullivan,* 523 F.2d 485 (7th Cir. 1975), the court in *Gould* emphasized that Inada (a case involving a threat by a police officer) dealt with a direct impingement of individual's rights, a situation not applicable to *Gould* and then went on to discuss the statutory violation and Supremacy clause. The point is, in *Gould,* where the court held that the action was not cognizable under §§ 1983 and 1988, it emphasized that a direct impingement of a fundamental right was a requisite.

In the instant case the nature of the action and the parties could certainly not result in any *direct impingement* or denial of a fundamental right. The record in this case does not indicate that the Fourteenth Amendment claims meet the substantiality test set out in *Hagans v. Levine,* 415 U.S. 528, 94 S.Ct. 1372, (1974). The merit

of respondent's constitutional claims are rendered suspect by its failure in the District Court to present any evidence of a substantial violation of due process or equal protection rights. This conclusion can be reached by a reading of the opinion of the District Court which found no violation of due process and the opinion of the Circuit Court which affirmed the District Court's holding. Furthermore, petitioners urge this court to note that respondent's Motion to file Supplemental Complaint designating the action of a § 1983 claim was filed approximately nine months after the filing of the complaint. In its first ruling, the District Court sustained the State's Objection for Leave to Amend. Then, following a Motion for Reconsideration based on the *Thiboutot* decision, the District Court vacated its previous order and permitted the plaintiffs to amend the Complaint to include the § 1983 designation and allegations. One can only conclude that the principal reason for the filing of the Amended Complaint with a § 1983 allegation was for the purpose of requesting and obtaining attorney fees under § 1988.

**III. The Decision Below Raises An Important Question Of Federal Law Which Has Not Been, But Should Be, Settled By This Court; And The Decision Is In Conflict With Applicable and Related Decisions Of The Federal Courts.**

The Eighth Circuit Court of Appeals relied primarily on *California Hospital Association v. Schweiker*, 559 F.Supp. 110, 117 (C.D. Cal. 1982), *aff'd*, 705 F.2d 466 (9th Cir. 1983) to support its position that the State's plan

was lacking in information necessary to meet the requirements of federal regulations and that this fact alone was sufficient to invalidate federal approval of the 3.75 percent cap for the fiscal year 1982-83. The Circuit Court then concluded that it was not necessary to reach the issue of whether the 3.75% limitation was arbitrary and capricious. The Circuit Court then adopted an observation of the District Court which concluded that the Nebraska Department of Social Services had not conducted objective analyses or studies to sufficiently determine the effect of § 68-720 (the 3.75 limitation on the level of care.) The Circuit Court then, without addressing the reasonableness of the limitation, stated there was sufficient basis for affirming the District Court's judgment enjoining the State from giving effect to § 68-720 for the fiscal year 1982-83.

Petitioner submits that the Eighth Circuit's reliance on *California Hospital Association v. Schweiker, supra,* conflicts with the analysis site out in *Wisconsin Hospital Association v. Reivitz,* 733 F.2d 1226 (1984), with respect to (1) the deference that should be granted to the approval of a plan by the federal agency and secretary, (2) the fact that plaintiffs have the burden to demonstrate a significant adverse impact on their services, finances or other relevant concerns, and (3) that the reasonableness of a rate may cover a zone and may not necessarily be defined by a single point. It should be noted that the holding in *California Hospital Association v. Schweiker, supra,* is distinguishable from the instant case in that the District Court in *Schweiker* concluded that the cap was arbitrary and capricious because of agency findings that were self-serving and false.

Petitioner submits that by relying on *California v. Schweiker*, and focusing principally on the details of the assurances submitted, the Eighth Circuit's decision did not give adequate considerations to points 1 and 3 cited above from *Wisconsin v. Reivitz*, that is, that deference should be granted to the agency and to the Secretary's approval and, moreover, that consideration should be given as to whether a rate is within a zone of reasonableness. Language from *Wisconsin Hospital Association v. Reivitz*, addresses the matter of the Secretary's approval or non-approval of a plan:

> While we do not think it is necessary, at this stage of the proceedings, to establish a threshold percentage at which the submission of assurances is required, scrutiny by HHS would do much to inform the district court as to the reasonableness and adequacy of the amended state plan under federal criteria. . . . However, such a prior determination seems particularly appropriate where the issue involves application of the reasonableness standard to a highly technical subject outside the conventional competence of courts.

*Wisconsin Hospital Association v. Reivitz, supra*, at 1235.

Petitioner submits that approval of the plan by the Secretary of the federal Department of Health and Human Services should be a factor of consideration as a court reviews a State plan to determine if it is within a "zone of reasonableness". Where, as in the present case, the federal agency charged with administering the Social Security Act approves the State plan, it expresses its view that the plan is in compliance with applicable federal statutes and regulations. The interpretation of such an agency is entitled to substantial deference. *Reese v.*

*Quern,* 606 F.2d 732, 736 (7th Cir. 1979), cert. denied, 449, U.S. 1079, 101 S.Ct. 860, 66 L.Ed.2d 802. See also, *Quern v. Mandley,* 436 U.S. 725, 98 S.Ct. 2068, (1978). Moreover, attached to the action of State administrative agencies is a presumption of validity. *Alabama Nursing Home Association v. Harris,* 617 F.2d 388, 393 (5th Cir. 1980). This view is in keeping with the legislative history of the Omnibus Budget Reconciliation Act of 1981, which established the new federal standards for hospital reimbursement rates found in 42 U.S.C. § 1396a(a) (13) (A):

> Congress intended that state authorities in developing methodologies for reasonable cost related reimbursement have great flexibility in the areas of cost-finding and rate-setting. The legislative history indicates that states are to be free to experiment with methods and standards for payment that would be simpler and less expensive than the complex Medicare reasonable cost formula period.

*Id.* at 392.

In *Reese v. Quern, supra,* the Seventh Circuit Court of Apeals in addition stated:

> By approving the Illinois Medicaid plan and by declining thus far to take any action against modification in the plan, the Department of Health. Education and Welfare [now the Department of Health and Human Services] has in effect expressed its view that the plan is in compliance with applicable statutory and regulatory requirements . . . The interpretation of the agency charged with administration of the statute is entitled to substantial deference.

*Reese v. Quern, supra,* at 735-36.

The necessity of deference and the importance of the Secretary's approval is emphasized by the District Court; in *Illinois Council on Long Term Care v. Miller*, 579 F.Supp. 1140 (N.D. Ill. 1983), wherein the court stated:

> The Secretary, however, has already accepted a version of the Illinois State Medicaid Plan as reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. The Secretary, therefore, has already accepted the state's system which puts a limit of [sic] the amount of mean nursing time that is reimburseable. Whether such a limit is now unreasonable under the Boren Amendment, in light of changes in the plan created by Public Act 83-17, or in light of changed patient care or patient profile conditions is also for the Secretary to determine.

*Id.* at 1150.

Thus, it is clear that the court in *Illinois Health Care Association v. Miller, supra,* placed greater reliance and granted greater deference to the role of the Secretary than did the District Court of Nebraska in the companion decision to the instant case, *Nebraska Health Care Association, Inc., v. Dunning,* 575 F.Supp. 176 (1983). In the instant case the District Court sustained the Motion of the Department of Health and Human Service for Summary Judgment against the plaintiff association's allegation that H.H.S. had failed to define the term "efficiently and economically operated." In its opinion, the District Court concluded that the Secretary's oversight power had been reduced significantly by reason of the federal budgetary legislation and cited that fact as a reason why California could properly accept assurances that later proved to be false. Obviously, in the *Illinois Health Care* case, with an

opinion filed the same year, the federal District Court did not feel that the approval by the Secretary was so perfunctory, and thus, in effect, gave greater deference to federal approval of a State plan. In short, the federal court's opinion in *Illinois Health Care* is in conflict with the decision of the United States District Court for the District of Nebraska in the instant case.

In addition, after considering the extent of the assurances, the Eighth Circuit Court concluded in its opinion that is was not necessary to reach the issue of the 3.75 percent cap. Appendix A. App. 29. The court's conclusion was in effect putting form over substance. By such a narrowing of the issues the Eighth Circuit Court did not address the issue of whether the rates were in the "zone of reasonableness" which was set out in *Wisconsin Hospital Association v. Reivitz, supra.* In *Reivitz* the court discussed the fact that, unlike reimbursement rates for hospitals, those for nursing homes were based on forecasts devised from the Consumer Price Index. The District Court in *Reivitz* declared the State's "freeze" unconstitutional because it did not take inflation into consideration. In the instant case, the very basis of the plan in Nebraska was to acknowledge inflation at a reasonable level. Consideration of that portion of the record would have enabled the Eighth Circuit Court to review the basis of the 3.75% limitation and decide whether it was in a zone of reasonableness as a forecasted percentage based on the actualities of that period.

In the District Court and in the Eighth Circuit Court of Appeals, the State argued that the 3.75% limitation set by Neb.Rev.Stat. § 68-720 (Cum. Supp. 1983) and the Department of Social Services rules promulgated thereun-

der, were in compliance with the substantive federal statutory requirements. By limiting its consideration to the extent of the studies included in the assurances made by the State to the Department of Health and Human Services, the Circuit Court was not able to address the reasonableness of the reimbursement rate in context. Such a review was necessary to determine whether the 3.75 percent limitation provides for the payment of rates to providers which are reasonable and adequate to meet the costs which much be incurred by efficiently and economically operated facilities.

———o———

## CONCLUSION

Perhaps the clearest reason for this Court to grant certiorari in the instant case is the fact that the courts below rendered decisions which are in conflict with other federal District Courts and other Courts of Appeal as to whether Medicaid providers are the intended beneficiaries of the Medicaid Program so as to have an action cognizable under 42 U.S.C. § 1983. Of further significance is the fact that other federal courts appear to be in conflict with the District Court and the Eighth Circuit Court on the subject of deference to the State agency formulating reimbursement plans and the Secretary's (HHS) approval.

Petitioner also submits that other federal courts have recognized *Thiboutot's* expansion of statutory claims under § 1983 and yet still attempt to limit a § 1983 designation and attorney fees pursuant to § 1988 to those cases involving an impingement of individual rights under the Supremacy clause, in direct contravention to the expansion

made by the District Court and the Eighth Circuit Court of Appeals below.

Given the disparity of decisions below, and the inapposite treatment of existing case law, petitioners respectfully urge that this Court grant the petition for certiorari to resolve the questions presented herein.

Respectfully submitted,

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## APPENDIX A

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

CV82-L-472

THE NEBRASKA HEALTH CARE ASSOCIATION, INC., et al,

Plaintiffs,

vs.

GINA DUNNING, Director of Nebraska Department of Public Welfare, et al,

Defendants.

MEMORANDUM AND ORDER

(Filed July 9, 1984)

This action concerns the propriety of certain actions taken by the Nebraska Legislature and several state officials in connection with the state's Medicaid program. Jurisdiction is based on the presence of a federal question.

Two of the plaintiffs are nonprofit corporations whose members include operators of long-term medical care facilities in Nebraska. These operators include local governments, nonprofit groups, and businesses; their facilities have been certified under the Medicaid program, 42 U.S.C. §§ 1396 et seq., and licensed by the State of Nebraska. Most serve both private patients and Medicaid patients. The other plaintiff operates a single facility in Nebraska. The defendants, who are sued in their official capacities, include the Director of the State Department

of Public Welfare (now known as the Department of Social Services) and the State Treasurer.

The Medicaid program is a cooperative venture between the federal government and participating states. When Nebraska joined the program, it agreed to follow the rules and requirements established by the federal government. Section 68-1021, R.R.S. Neb. (Reissue 1981); *Harris v McRae,* 448 U.S. 297, 301 (1980). Subject to these requirements, the federal government allows Nebraska to determine the rate at which long-term care facilities will be reimbursed for serving Medicaid patients. Nebraska must assure the federal government that these rates satisfy certain requirements. See 42 C.F.R. § 447.252 through § 447.255. If the federal government approves the rates, then it and local governments supply a substantial share of the funds used to pay the rates. In Nebraska, the Department of Public Welfare is responsible for setting rates and implementing the Medicaid program.

Although Nebraska sets its reimbursement rates, it must pay for:

> " . . . the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in acccordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographical lo-

cation and reasonable travel time) to inpatient hospital services of adequate quality."

42 U.S.C. § 1396a(a)(13)(A)

The statute allows Nebraska to define what is an efficiently and economically operated facility and determine what costs such a facility must incur, subject to federal approval.

In 1981, Nebraska did this through a retrospective payment plan. At the end of its fiscal year, a facility would give the Department of Public Welfare a report of the costs it had incurred in serving Medicaid patients. The department then subtracted those costs which were not allowable—i.e., it would not pay for steak if the patients' dietary needs could be satisfied with hamburger. This produced the facility's "allowable cost," per Medicaid patient day, which then was compared with the allowable costs of other facilities in the same class. The department ranked all the facilities in a class by allowable costs, with the least expensive on top and the most expensive at the bottom. The department then selected the percentile for which it would pay all allowable costs. If, for example, it selected the 82nd percentile, and the skilled nursing facilities in the state had provided 100,000 days of Medicaid care, those facilities which had provided the least expensive 82,000 days of Medicaid service were paid their full allowable costs for the preceding year. The remaining more expensive facilities—i.e., those in the 83rd to 100th percentiles—received only the rate paid to the 82nd percentile facility; this gave them incentive to reduce their costs during the year to below those of the 82nd percentile.

In late 1981, the department began work on a prospective plan, under which a facility's 1981 costs would be

used to calculate its 1982 rates, although a five per cent allowance was added for inflation. The prospective plan said it would pay the allowable costs for a minimum of 65 per cent of the Medicaid patient days—i.e., it would pay the full allowable costs of all facilities ranking about the 65th percentile. However, for reasons which the record does not reveal, the department adopted an unwritten policy of paying the full allowable costs of facilities at the 82nd percentile. The plan also provided an incentive allowance of up to fifty cents per patient-day for nonprofit facilities and one dollar for profit facilities whose costs were below the 82nd percentile. If a nonprofit facility's allowable cost was more than fifty cents below the 82nd percentile's cost, it received the full incentive payment; if it was only thirty cents below, it received the thirty cents.

On July 1, 1982, §§ 68-720 and 68-721, R.R.S. Neb. (1982 Cum. Supp.) took effect. Section 68-720 said that a facility's rate for the 1982-1983 fiscal year could not exceed its rate as of April 1, 1982, by more than 3.75 per cent. Section 68-721 said:

> "If, at any point in the state fiscal year, Medical Assistance funds are being expended at a rate that would exceed funds available for Medical Assistance expenditures for the fiscal year, the Director of Public Welfare shall impose a pro rata reduction of all allowable costs for optional services. . . . Such reduction shall be a percentage designed to bring the rate of expenditures into line with available funds. If at any time such cuts for optional services amount to a pro rata reduction of ten percent for such optional services covered by this section, the Director of Public Welfare shall impose a pro rata reduction on all services provided by Medical Assistance on an equal

> percentage for all such further reductions in payments."

Later that month, the new prospective rate state plan was sent to the Health Care Financing Administration's regional office. The administration is a part of the Department of Health and Human Services and is responsible for approving state Medicaid plans. 42 C.F.R. § 447.256. The state plan said it would ensure that allowable costs would be met for a minimum of 65 per cent of the Medicaid patient days. It also contained provisions implementing §§ 68-720 and 68-721. The plan was accompanied by certain assurances included pursuant to 42 C.F.R. §§ 447.252 and 447.255. On September 22, 1982, the regional office approved the plan, effective August 1, 1982. Later, however, it informed Nebraska that it could not approve the provisions for pro rata cuts unless it received more information; apparently, it did not protest the 3.75 per cent limitation.

The change from a retrospective to a prospective plan required a transition period, in part because it required all facilities to adopt the same fiscal year for cost-reporting purposes. Under the old plan the reporting deadlines for facilities had been staggered throughout the year. To reach a standard data base, the department required each facility to report its costs from the date of its last report until July 31, 1982. The resulting allowable costs were then converted into an annual "adjusted cost," so that the department could compare the costs of facilities which had reported one month's costs, for example, with those which had had to report costs incurred for more than one month. The adjusted cost included a five per cent inflation adjustment. The department then compared each facility's

adjusted cost per day against three other figures: the first was the facility's April 1, 1982, rate plus 3.75 per cent, as mandated by § 68-720; the second figure was the facility's patient rate; and the third figure was the 82nd percentile rate for the facility's class. The lowest of these four numbers set the facility's reimbursement rate from August through December 1982.

In early 1983 the regional office asked Nebraska to delete from its state plan the provision allowing for emergency pro rata cuts; it said such cuts would be based solely upon budgetary considerations and would destroy the validity of the assurances Nebraska had earlier submitted as to the effect of its rates. On March 29, 1983, the department's director, Gina Dunning, told the federal government that she was deleting this provision from the state plan. On the same day, however, she issued a news release announcing that pro rata cuts were being implemented pursuant to § 68-721 because of a financial emergency. She said that payment rates to intermediate care facilities would be cut 14.4 per cent and skilled nursing facility rates would be reduced 4.4 per cent; the reductions would be in effect from April 1, 1983, until the end of the fiscal year. Dunning did not tell the federal government of her actions, nor did she reveal to the public that she had withdrawn from the state plan the provisions she was invoking to make the pro rata cuts. At trial, I received no explanation for this contradictory behavior.

On April 1, 1983, I conducted a hearing at which the plaintiffs, the state defendants, and the federal defendant were represented; following the hearing, I temporarily enjoined the state defendants from implementing the an-

nounced pro rata cuts. *Nebraska Health Care Association, Inc. v. Dunning,* 578 F. Supp. 543. Five days later, Dunning sent the federal government a state plan adding the pro rata reductions provisions she supposedly had deleted earlier and whose implementation I had enjoined. In May, the federal government approved an earlier-submitted state plan which did not include the pro rata cut provisions. Soon thereafter, the Nebraska legislature amended § 68-720 so that its limitation also applied to the 1983-1983 fiscal year. On June 2, 1983, Dunning again withdrew the pro rata reduction provision from the state plan. I do not know whether she or anyone else informed the federal government of § 68-720's extension or whether the federal government has reacted to that extension.

Trial was held on December 19 and 20, 1983.

The first three controverted issues listed in the pretrial order, filing 61, ask whether § 68-270's 3.75 per cent limitation prevents the payment of rates which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities, as required by 42 U.S.C. § 1396a(a) (13) (A) and 42 C.F.R. § 447.252, thereby violating the supremacy clause of the Constitution; whether the Nebraska Public Welfare Manual, IX-6000, Supp. A, -1500, § 6, which implements § 68-720's limitation, also violates the supremacy clause; and whether the defendants' implementation of the statute and the manual's provisions violated 42 U.S.C. § 1983 by depriving the plaintiffs of their rights under 42 U.S.C. § 1396a (a) (13) (A).

All of the plaintiffs have standing to raise these issues.

The defendants contest the plaintiffs' invocation of the supremacy clause and § 1983. The plaintiffs' use of the supremacy clause to attack state statutes or regulations which conflict with federal law is proper, *Blum v Bacon*, 457 U.S. 132, 138 (1982), including those which conflict with Medicaid laws, *Wisconsin Hospital Association v Reivitz*, No. 82-C-1055 (U.S.D.C. E.D. Wis. January 11, 1983), CCH Medicare/Medicaid Guide, ¶ 32,380. at 9898, reversed on other grounds, 52 U.S.L.W. 2671 (C.A. 7th Cir. May 8, 1984). As for the plaintiffs' use of § 1983 to challenge the defendants' implementation of allegedly unconstitutional statutes and regulations, suits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act by participating states, *Maine v Thiboutot*, 448 U.S. 1, 4 (1980); *Blue v Craig*, 505 F. 2d 830, 832-833 (C.A. 4th Cir. 1974), including suits by Medicaid service providers to challenge the wrongful administration of a Medicaid program by a state. *Yapalater v Bates*, 494 F. Supp. 1349, 1357-1358 (U.S.D.C. S.D. N.Y. 1980), aff'd 644 F.2d 131 (C.A. 2nd Cir. 1981), cert. denied 455 U.S. 908 (1982).

My examination of the propriety of the 3.75 per cent limitation must begin by recognizing that a state-imposed limitation upon cost increases is not improper per se; the question is whether the limitation is so arbitrary or capricious that it prevents proper reimbursement under 42 U.S.C. § 1396a(a) (13) (A). *California Hospital Association v Obledo*, 602 F.2d 1357, 1361 (C.A. 9th Cir. 1979); *Wisconsin Hospital Association v Reivitz*, 52 U.S.L.W. 2671 (C.A. 7th Cir. May 8, 1984); Cf. *Children's Hospital v Secretary of Department of Public Welfare*, 568 F. Supp. 1001, 1010 (U.S.D.C. E.D. Pa. 1983); H. Conf. Rep. No. 208, 97th Cong., 1st Sess., at 962, reprinted in 1981 U.S.

Code Cong. and Admin. News 1010, 1324; 43 Fed. Reg. 4861, 4862 (1978).

The testimony and exhibits show that the 3.75 per cent limitation prevents proper reimbursement and is arbitrary and capricious. The most telling evidence is provided by Exhibits 153, 154, and 156, which are based on data supplied by the Department of Public Welfare. Figures by the plaintiffs are somewhat different, but I have used the exhibits showing department figures. Using these exhibits, I have calculated the total number of facilities receiving payments for both payment periods, the number of facilities whose adjusted allowable costs (as calculated by the department) were at or below the 65th percentile, and the number of those facilities which because of the 3.75 per cent limitation were not paid for their adjusted allowable expenses:

| Facility Type | Total Number | Facilities with adjusted costs at or below 65th Percentile | Facilities below 65th Percentile yet denied full adjusted costs by 3.75 per cent limit |
|---|---|---|---|
| Skilled Nursing | | | |
| 1982* | 17 | 12 | 3 |
| 1983 | 17 | 12 | 10 |
| Intermediate Outstate | | | |
| 1982* | 158 | 107 | 11 |
| 1983 | 158 | 107 | 85 |
| Intermediate Metropolitan | | | |
| 1982* | 30 | 24 | 2 |
| 1983 | 30 | 24 | 15 |

* August 1, 1982, through December 31, 1982

| Facility Type | Total Number | Facilities with adjusted costs at or below 65th Percentile | Facilities below 65th Percentile yet denied full adjusted costs by 3.75 per cent limit |
|---|---|---|---|
| Intermediate Mentally Retarded | | | |
| 1982* | 7 | 4 | 0 |
| 1983 | 7 | 4 | 4 |
| Skilled Nursing, Hospital Based | | | |
| 1982* | 9 | 5 | 1 |
| 1983 | 9 | 5 | 5 |
| Intermediate, Hospital Based | | | |
| 1982* | 25 | 23 | 17 |
| 1983 | 25 | 23 | 21 |

*August 1, 1982, through December 31, 1982

In other words, during the transition period of the last five months of 1982, there were 177 facilities whose adjusted costs were at or below the 65th percentile and 34 of those facilities did not receive reimbursement for all of their adjusted allowable costs, solely because of § 68-720. In 1983, 131 of the 177 facilities suffered the same fate.

These numbers are important, because the state plan approved by the federal government said Nebraska would set rates so as to ensure that allowable costs were met for a minimum of 65 per cent of the Medicaid patient days—i.e., the 65th percentile. By saying that it would set rates at the 65th percentile, the state said in effect that facilities whose adjusted allowable costs were equal to the 65th per-

centile's costs were efficiently and economically operated facilities; the state's calculation of which costs were allowable eliminated those incurred expenses which were not reasonable or necessary for these efficiently and economically operated facilities. These determinations by the state, after approval by the federal government, meant that the adjusted allowable costs of a facility at the 65th percentile for its classification was the reimbursement rate required under 42 U.S.C. § 1396a(a)(13)(A). The statistics I have presented show that § 68-720 has deprived a large number of facilities of this rate, which they were entitled to receive. I have no statistics to determine the exact effect of § 68-720's extension to the 1983-1984 fiscal year, but the continued effects of inflation ensure that the extension would deprive an even larger number of facilities of the payments to which they are entitled.

The plaintiffs argue that the department has determined that the rates should be based on the 82nd percentile rather than the 65th percentile, which would make the 82nd percentile adjusted allowable costs the rates required by federal law. The testimony of Robert Seiffert and Donald Gerber support this; both admitted that payment of 82nd percentile costs recognized that facilities at the 82nd percentile were efficiently and economically operated. The defendants argue that it is impossible to define what constitutes an efficiently and economically operated facility and that a range of rates can satisfy § 1396a(a)(13)(A). This is supported by the fact that the federal government approved the state plan's written provision for payment at the 65th percentile rate. I need not decide the question, however, because the statistics based on the lower, 65th percentile rate are sufficiently disturbing to obviate the

need to look at rates based on the 82nd percentile, which would show even more facilities not receiving proper reimbursement.

My statistical concerns about the effect of the 3.75 per cent limitation are reinforced by the testimony of a number of nursing home administrators. These administrators testified that the limitation has prevented them from receiving sufficient payment to cover those costs which they have had to incur. They said that the continued use of the limitation would force them either to reduce services to Medicaid patients or to increase the rates they charge to private patients. The former option could prevent them from meeting federal and state licensing and safety standards and could harm their Medicaid patients; the latter places and unfair burden upon private patients. See *Minnesota Association of Health Care Facilities. Inc., v Minnesota Department of Public Welfare,* 602 F.2d 150, 154 (C.A. 8th Cir. 1979).

The defendants attack this testimony on two grounds. First, they assert that the facilities could stay within the 3.75 per cent limitation by limiting wages, which comprise a large part of operating costs, and by reducing administrative and other positions. They presented no evidence to support the latter assertion; indeed, the administrators' testimony showed the contrary. The only evidence to support the former assertion were several conclusionary statements by witnesses who had never operated a nursing home. The defendants introduced no evidence to show that wage freezes or reductions were possible at any facility in Nebraska, while the plaintiffs' witnesses explained how such freezes or reductions would increase employee

turnover, causing decreased care to patients and higher training costs.

The defendants' other argument was that many facilities affected by the 3.75 per cent limitation still produced profits or income surpluses. As I indicated at trial, this information is irrelevant. The defendants introduced no evidence to show that these profits came from Medicaid payments, and such evidence would be inconsistent with the defendants' actions in setting those payment rates. When a facility submits its report on all of its Medicaid expenses, the defendants are responsible for weeding out those which are unreasonable or unnecessary in order to produce the facility's allowable costs, and reimbursement is limited to those allowable costs which actually have been incurred. By the state's own terms, any profit must come from the incentive rate system.

In 1983, the 3.75 per cent limitation prevented 136 facilities from receiving the incentive rate permitted to them under the state plan; 130 of those facilities did not receive full payment for even those incurred expenses which the state said were permissible. These 130 facilities, by the state's own definitions, lost money on Medicaid patients. The defendants point out that many Medicaid costs are lumped together with non-Medicaid costs, and imply that the allowable costs as determined by the state may include non-Medicaid costs. There was no evidence of that, and if it were true, it would be the state's own fault. I note that in some circumstances, a certain amount of profit is a reasonable and necessary part of reimbursement rates. See *California Association of Bioanalysts v Rank*, 577 F. Supp. 1342, 1359 (U.S.D.C. C.D. Cal. 1983);

*Country Club Home, Inc. v Harder,* 620 P.2d 1140, 1151 (Kan. 1980).

The defendants argue that the 3.75 per cent limitation is an attempt to limit rate increases to those required by inflation, pointing out that the Consumer Price Index-Urban shows a national inflation rate of 2.6 per cent from June 1982 until June 1983. This argument suffers several flaws, however. First, the defendants did not explain why this was the appropriate index to use. It may be that the overall rate for Kansas City is more appropriate and that rate for June 1982 to June 1983 was 5.6 percent—well over § 68-720's 3.75 per cent rate. And it may be that the appropriate price index was the one calculated for medical care, which throughout the period covered by Exhibit 280 was far higher than 3.75 per cent. Furthermore, the June 1982-June 1983 rate is inappropriate. Section 68-720 says the base rate is the rate on April 1, 1982, and it applies the limitation until June 30, 1983. This is a fourteen-month period, not a twelve-month period as used in Exhibit 280. The national urban index from April 1982 until April 1983 rose 3.9 per cent, and the inflation which occurred in May and June of 1983 would raise that rate even higher.

Second, the testimony indicated that § 68-720 was not based upon any predicted inflation rate. The plaintiffs stress the testimony of Melvin Clothier, the administrator of the Medical Division of the Department of Public Welfare, who said that the legislature chose 3.75 per cent because it expected to give a 3.75 per cent pay increase to state employees that year. The defendants, although contending that § 68-720 was intended as an inflation limitation, were unable to show that when the legislature

adopted § 68-720, it was aware of any prediction that inflation would be limited to 3.75 pre cent from April 1982 until June 30, 1983. Nor could the defendants identify any price index which showed that inflation during that period actually was 3.75 per cent.

Third, any argument that the legislature meant § 68-720 to limit facility cost increases to those necessitated by inflation is rebutted by the legislature's decision in the spring of 1983 to extend § 68-720's application until June 30, 1984. This means that a facility's costs on that date may be no more than 3.75 per cent above the costs it incurred thirty-three months earlier. This produces an inflation allowance of about 1.36 per cent a year, which clearly is arbitrary and capricious. Indeed, the department itself used a five per cent inflation allowance in calculating the August-to-December 1982 rates.

It is true that the federal government approved a state plan which implemented § 68-720 for 1982 and 1983, and that fact is entitled to deference. It is also true that the public welfare department has special expertise in this area, which means that its assurance to the federal government about the adequacy of that state plan also should be entitled to deference. But the defendants admit that the department did not conduct any objective analysis or studies to determine the effects of §68-720's limitation on the level of care Mericaid patients would receive or the extent to which facilities would continue to participate in Medicaid. This means that there is no objective evidence to support the assurances which the department gave to the federal government. Therefore, the department's assurances are entitled to no deference; with no factual basis to support them, they must be regarded as arbitrary

and capricious. This means, then, that the federal government's approval, which was based on those unsupported assurances, is not entitled to deference. A state plan approved by the federal government is invalid when it is accompanied by false or inaccurate assurances, *California Hospital Association v Schweiker,* 559 F. Supp. 110, 117 (U.S.D.C. C.D. Cal. 1982), aff'd 705 F.2d 466 (C.A. 9th Cir. 1983), or by assurances which were not supported by objective studies, *Washington State Hospital Association v Schweiker,* No. C82-1115-JLW, unpublished memorandum at 12-13 (U.S.D.C. W.D. Wash. January 12, 1983; *Oklahoma Hospital Association v Oklahoma Department of Human Services,* No. CIV83-1274-BT (U.S.D.C. W.D. Okla. August 24, 1983), CCH Medicare/Medicaid Guide, ¶ 33,057, at 10,247. Cf. *Thomas v Johnston,* 557 F. Supp. 879, 906, 910 (U.S.D.C. W.D. Tex. 1983).

The defendants argue that their implementation of § 68-720 by writing its limitation into the state plan and the state public welfare manual, despite their failure to study its effects, was not arbitrary and capricious, because the statute required them to take such action. This misses the point of 42 C.F.R. §§ 447.250 et seq. Even though § 68-720 required the department to take certain actions, the department had a responsibility to tell the federal government what the effects of those actions would be so that the federal government could decide whether the state, via the legislature, had failed in its promise to abide by federal Medicaid requirements.

Therefore, I must find for the plaintiffs on controverted issues numbered one through three.

Controverted issues four and five ask whether § 68-721, R.R.S. Neb., which mandates pro rata reductions in rates

in the event of a fiscal emergency, and the Department of Public Welfare's attempt to implement such reductions, violated the supremacy clause of the Constitution and deprived the plaintiffs of their rights under 42 U.S.C. § 1396a (a)(13)(A). The reductions were mandated when the director of the Department of Public Welfare determined in March of 1983 that Medicaid funds were being spent at a rate which would deplete the Medicaid appropriation before the end of the year. The director's decision meant that payments to intermediate care facilities would have been cut 14.4 per cent from April 1, 1983, until June 30, 1983, and payments to skilled nursing facilities would have been reduced 4.4 per cent. I note that the withdrawal of the pro rata reductions by the director does not moot the case, because this is a situation which is capable of repeating itself while evading review as long as § 68-721 remains in force. See *Sosna v Iowa,* 419 U.S. 393, 399, 400 (1975).

Four factors persuade me that § 68-721 arbitrarily and capriciously denies Medicaid care providers reasonable and adequate reimbursement for expenses which they had to incur as efficiently and economically operated facilities. First, the federal government has told the defendants that the state plan's provision for pro rata cuts is unacceptable. A state plan cannot be used until the federal government approves it. *California Hospital Association v Obledo,* 602 F.2d 1357, 1361-1363 (C.A. 9th Cir. 1979). The federal government has pointed out that if such reductions are implemented, the assurances submitted earlier by the state are no longer valid. The federal government said the same thing in *Bolivar Nursing Home v Missouri Department of Social Services,* No. CV183-76CC (Circuit

Court of Cole County, Missouri, March 18, 1983), and its interpretation of the Medicaid statutes and regulations is entitled to substantial deference.

Second, prior to their decision to implement the reductions, the state defendants did not conduct any analysis or studies to determine the effect of such reductions on Medicaid services. As I said earlier, such studies are needed before the state can properly assure the federal government that its rates satisfy 42 U.S.C. § 1396a(a)(13)(A).

Third, although a few courts have declined to strike down pro rata reductions in certain circumstances, see *Coalition of Michigan Nursing Homes, Inc. v Dempsey,* 537 F. Supp. 451 (U.S.D.C. E.D. Mich. 1982) (no showing that 33 per cent reduction in profit allowance would affect Medicaid services adversely); *California Association of Bioanalysts v Rank,* 577 F. Supp. 1342 (U.S.D.C. C.D. Cal. 1983) (no showing of adverse effects); *New Jersey Federation of Physicians and Dentists v Klein,* 144 N.J. Super. 467, 366 A.2d 341, 344 (1976) (same), a number of courts have permanently or temporarily enjoined pro rata reductions because they were based solely on budgetary considerations and because they would harm Medicaid patients. *Illinois Hospital Association v Illinois Department of Public Aid,* 576 F. Supp. 360 (U.S.D.C. N.D. Ill. 1983); *Illinois Health Care Association, Inc. v Quern,* No. 77-C-1109 (U.S.D.C. N.D. Ill. January 31, 1983), CCH Medicare and Medicaid Guide, ¶ 32,396; *Ash Grove Nursing Home, Inc. v Missouri Department of Social Services,* No. 83-4023-CV-C-5 (U.S.D.C. W.D. Mo. February 11, 1983). Other courts have struck down legislatively determined rates because they were based solely on budget-

ary constraints. *Thomas v Johnston,* 557 F. Supp. 879, 914 (U.S.D.C. W.D. Tex. 1983); *Oklahoma Hospital Association,* supra, at 10,246-10,247, 10,250; *Illinois Hospital Association,* supra, 576 F. Supp. at 368. See, also *Alabama Nursing Home Association v Harris,* 617 F.2d 388, 396 (C.A. 5th Cir. 1980); *Mississippi Hospital Association v Heckler,* 701 F.2d 511, 518 (C.A. 5th Cir. 1983). This is because when a rate is based on budgetary considerations, it cannot be based on the factors required by 42 U.S.C. § 1396a(a)(13)(A).

Section 1396a(a)(13)(A) requires reimbursement of reasonable costs which must be incurred by an efficiently and economically operated facility. The state already has determined the reasonable costs of each facility in Nebraska. The pro rata reductions would have reduced the reimbursement for each facility in the state—including the most efficient facilities—below the amount needed to reimburse for those reasonable costs. The adverse effect of these reductions is magnified by the fact that efficiently and economically operated facilities in many cases now are not receiving adequate reimbursement for their allowable costs because of the 3.75 per cent limitation.

The fourth factor, which reinforces the concerns I have just expressed, is the testimony of several nursing home administrators as to the effect of the pro rata cuts. This testimony is similar to that about the effect of the 3.75 per cent limitation. The state's only rebuttal argument is that the reductions would have been in effect for only a few months, so the 14.4 per cent reduction for intermediate care facilities would reduce a facility's annual revenues by only 2.4 per cent. This argument ignores two

points: the reductions would have occurred at the end of each facility's fiscal year and each facility would have had to absorb the full reduction in the space of two or three months; and the reduction, whatever its size, applied to all facilities, including those which are the most efficient in the state, and these facilities would not receive reimbursement as required by federal law.

The twelfth and thirteenth controverted issues in the pretrial order ask whether certain aspects of the public welfare department director's implementation of the pro rata cuts and her subsequent withdrawal of those reductions without a public rule-making hearing denied the plaintiffs their right to due process. I do not believe that the plaintiffs were entitled to such a hearing, because the director's implementation of the reductions and her subsequent withdrawal were mandated by the Nebraska legislature's adoption of § 68-721. When Dunning determined that Medicaid expenses would exhaust appropriations before the end of the fiscal year, she was required by § 68-721 to implement specified reductions; when the emergency was relieved by new appropriations and the end of the fiscal year, she was required to withdraw those reductions. Whatever rights of due process the plaintiffs enjoyed were satisfied during the legislature's proceedings which adopted § 68-721. See *California Association of Bioanalysts v Rank,* supra, at 1348; *Claus v Smith,* 519 F. Supp. 829, 833 (U.S.D.C. N.D. Ill. 1981). Furthermore, my April 1, 1983, injunction prevented the implementation of the reductions from harming the plaintiffs, and I see no way in which the withdrawal of the reductions injured them.

The twentieth controverted issue asks me to determine what analyses, studies, or factual data are required to support the Department of Public Welfare's assurances and state plan. This requests an advisory opinion, and I decline to give one. The twenty-first controverted issue has already been answered.

The final controverted issue concerns the plaintiffs' entitlement to attorneys' fees under 42 U.S.C. § 1988. I shall reserve a ruling on this until after the parties have briefed the issue and submitted the necessary documentation.

IT THEREFORE IS ORDERED:

1. That §§ 68-720 and 68-721 are declared to be unconstitutional;

2. That Gina Dunning, Director of the Nebraska Department of Public Welfare; Kay Orr, Treasurer of the State of Nebraska; Clifton A. Sexton, Jr., Director of the Nebraska Department of Administrative Services, and their agents, employees, attorneys, successors, and those persons in active participation with them, are permanently enjoined from implementing Section 6 and Section 9 of L.B. 942 of the Second Session of the Eighty-Seventh Legislature of the State of Nebraska, 1982, now codified in §§ 68-720 and 68-721, R.R.S. Neb. (1982 Cum. Supp.), and Section 1 of L.B. 618 of the First Session of the Eighty-Eighth Legislature of the State of Nebraska, 1983, now codified in § 68-720, R.R.S. Neb. (1983 Supp.);

3. That final judgment will be withheld pending determination of the plaintiffs' right to attorneys' fees; and

4. That the plaintiffs are given ten days from the date of this order in which to make a showing regarding attorney's fees and the defendants are given ten days thereafter in which to respond.

Dated July 9, 1984.

BY THE COURT

/s/ Warren K. Urbom
Chief Judge

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UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 84-2397

The Nebraska Health Care Association, Inc., a Nebraska Nonprofit Corporation; The Evangelical Lutheran Good Samaritan Society, a North Dakota Nonprofit Corporation; W.S.T. Care, Inc., d/b/a Crestview Care Center, a Nebraska Corporation,

Appellees,

v.

Gina Dunning, Director of the Nebraska Department of Public Welfare; Kay C. Orr, Treasurer of the State of Nebraska; Clifton A. Sexton, Jr., Director of Administrative Services,

Appellants.

On Appeal from the United States District Court
for the District of Nebraska.

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Submitted: September 9, 1985*
Filed: December 9, 1985

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* This case was argued on May 17, 1985. Post-argument briefs were requested by the Court, the last of which was received the panel on September 9, 1985.

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Before LAY, Chief Judge, ARNOLD, Circuit Judge, and REGAN,** Senior District Judge.

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ARNOLD, Circuit Judge.

The question presented is whether certain Nebraska statutes regulating reimbursement to providers of nursing-home services under the Medicaid program conflict with the requirement of the Social Security Act, 42 U.S.C. § 1396a(a) (13) (A) that reimbursement rates must be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. . . ." The plaintiffs, representing operators of long-term medical-care facilities, challenged the application of the state laws in question with respect to two fiscal years, 1981-82 and 1982-83. The District Court[1] held both statutes unconstitutional under the Supremacy Clause, finding them inconsistent with federal law. On this appeal, defendants, who are state officials, have abandoned their attempt to uphold one of the challenged statutes. As to the other state law in question, we hold that the state's submission seeking approval of its reimbursement plan for the fiscal year 1982-83 failed to comply with the plain terms of federal regulations. The judgment of the District Court, enjoining enforcement by the state of its plan, is therefore affirmed as to the first of the two fiscal years in question.

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** The Hon. John K. Regan, Senior United States District Judge for the Eastern District of Missouri, sitting by designation.

1 The Hon. Warren K. Urbom, Chief Judge, United States District Court for the District of Nebraska.

As to the second fiscal year, we hold that the case is not yet ripe for judicial determination. An administrative proceeding is still pending within the Social Security Administration with respect to fiscal year 1983-84. We therefore affirm in part, vacate in part, and remand for further proceedings on the issue of attorneys' fees.

I.

The Medicaid program is a joint venture between the federal government and participating states. When a state decides to participate, as Nebraska has, it must submit to the Department of Health and Human Services a satisfactory state plan which meets the payment standard of the Boren Amendment, codified at 42 U.S.C. § 1396a(a) (13) (A) (Supp. 1985). That statute provides in relevant part:

> (a) Contents
>
> A State plan for medical assistance must—
>
> • • • •
>
> (13) provide—
>
> (A) for payment . . . of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards. . . .

In 1981, Nebraska established a payment plan including its definition of an efficiently and economically oper-

ated facility. Under this plan, the nursing homes would give the Nebraska Department of Public Welfare[2] (DPW) a report of their costs for Medicaid patients at the end of the fiscal year. DPW would then subtract any costs not allowed and compute each nursing home's "allowable cost" per Medicaid patient day. This figure is then compared with other nursing homes in the same class, and they are ranked from the least expensive to the most expensive. The Department then selected the 65th percentile as the one at which it would pay all allowable costs. Under this plan, if nursing homes as a whole provided 100,000 days of Medicaid care, then the nursing homes with the least expensive 65,000 days would be paid their full allowable costs for the preceding year. Those in the 66th to 100th percentiles would be paid the same rate as those homes at the 65th percentile. Although the plan as written was designed to pay for a minimum of 65 per cent. of Medicaid patient days, DPW's actual practice was to pay the full allowable costs up to the 82nd percentile.

In August 1982, DPW, pursuant to a new statute, Neb. Rev. Stat. § 68-720 (Supp. 1983) amended its plan for reimbursement to nursing homes. The amended plan provided that payments to a vendor of Medicaid services for fiscal year 1982-83 would be limited to the reimbursement allowed to that vendor on April 1, 1928, plus 3.75

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[2] The name of the department has since been changed to the Nebraska Department of Social Services. See Neb. Rev. Stat. § 68-701 (Supp. 1983).

per cent. This "cap" was later extended by the Legislature to a second fiscal year, 1983-84.[3]

Late in July of 1982, the new state plan was sent to the regional office of the Health Care Financing Administration for approval. This administration is a part of the Department of Health and Human Services and is responsible for approving state Medicaid plans. 42 C.F.R. § 447.256. The plan contained a provision implementing § 68-720, the 3.75 per cent. "cap." On September 22, 1982, the regional office approved the plan for the fiscal year 1982-83. (Fiscal years for this purpose apparently begin on August 1.)

Later, in the spring of 1983, the Nebraska Legislature extended the 3.75 per cent. "cap" until June 30, 1984. On February 15, 1984, after the case was tried in the District Court but before it was decided, the extension of the 3.75 per cent. limitation for a second fiscal year was disapproved, apparently by the regional office of the Health Care Financing Administration. We were informed at the oral argument that the propriety of this disapproval is now pending on some kind of administrative appeal within HHS, proceedings which HHS has stayed pending the outcome of this lawsuit.

The District Court held that the 3.75 per cent. limitation prevented proper reimbursement under § 1396a(a)

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[3] The Legislature also enacted § 68-721 (1982 Cum. Supp.), providing for a pro rata reduction in reimbursements "[i]f, at any point during the fiscal year Medical Assistance funds are being expended at a rate that would exceed funds available for Medical Assistance expenditures for the fiscal year. . . ." The District Court held this statute also invalid as in conflict with the Boren Amendment. Defendants do not contest this holding on appeal, see Brief for Appellants 2, so we do not address the issue.

(13)(A). It found as a fact that during the last five months of 1982, 177 facilities incurred allowable costs at or below the 65th percentile, but 34 of those facilities did not receive reimbursement for all of their allowable costs solely because of § 68-720. In 1983, the Court further found, "131 of the 177 facilities suffered the same fate." *The Nebraska Health Care Association v. Dunning,* No. CV82-L-472 (D. Neb. July 10, 1984), slip op. 6. The state's plan, the District Court reasoned, "said in effect that facilities whose adjusted allowable costs were equal to the 65th percentile costs were efficiently and economically operated facilities . . . ." *Id.* at 7. A state statute whose operation prevented reimbursement of a significant number of facilities at a level found reasonable by the state did not satisfy the Boren Amendment. This appeal followed.

II.

As to fiscal year 1982-83, we affirm, though on a somewhat different basis from that used by the District Court. The uncontradicted record in this case shows that the state's submission of its plan for the fiscal year 1982-83 failed to submit crucial information required by regulations of the Health Care Financing Administration. HCFA's purported approval of the 3.75 per cent. limitation was, therefore, invalid, and the state had no right to put this portion of its plan into effect, unless, of course, it chose to do so solely with its own funds, which it has not done.

When state plans are submitted, the relevant state agency must make certain findings and submit certain assurances and related information for consideration by

HCFA. These requirements are set out at 42 C.F.R. §§ 447.250-.272 (1982).[4] The state Medicaid agency, here DPW, must submit, along with these assurances, the amount of the average proposed payment rate for the various types of long-term care providers and the amount of increase or decrease from the last rate period. The state must also provide:

> (2) A quantified estimate of the short-term and, to the extent feasible, long-term effect the changes in the rate will have on—
>
> (i) The availability of services on a Statewide and geographic area basis;
>
> (ii) The type of care furnished (for example, secondary or tertiary care);
>
> (iii) The extent of provider participation; and
>
> (iv) The degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

42 C.F.R. § 447.255(b) (1982).

As the District Court observed,

> The defendants admit that the department did not conduct any objective analysis or studies to determine the effects of § 68-720's limitation on the level of care Medicaid patients would receive or the extent to which facilities would continue to participate in Medicaid.

Slip op. 9. Thus, the quantified estimates of various effects of the 3.75 per cent. limitation, required to be submitted by the applicable regulation, which we have quoted, could not have been submitted, because the state never

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[4] We cite the 1982 version of the regulations because they were in effect at the relevant times.

conducted any objective analysis or studies to determine these effects. Accordingly, as the District Court found, "there is no objective evidence to support the assurances which the department gave to the federal government." *Id.* at 10. The state's submission of its new plan was simply not accompanied by any information even purporting to meet the requirements of the federal regulation. This fact, without more, is sufficient to invalidate HCFA's purported approval of the 3.75 per cent. "cap" for the fiscal year 1982-83. There was no factual basis for the assurances Nebraska submitted to HCFA, and HCFA's approval, being based on unsupported assurances, is without legal effect. See *California Hospital Ass'n v. Schweiker*, 559 F. Supp. 110, 117 (C.D. Cal. 1982), *aff'd*, 705 F.2d 466 (9th Cir. 1983).

It is therefore unnecessary for us to reach the District Court's conclusion that the 3.75 per cent. limitation was arbitrary and capricious, or to review its factual findings as to this limitation's effect in practice. The failure of the state to satisfy the requirements of federal regulations when the plan was submitted is a sufficient basis for affirming the District Court's judgment enjoining the state from giving effect to § 68-720 with respect to fiscal year 1982-83.

III.

The same result does not necessarily follow, however, with respect to fiscal year 1983-84. As to this year, HCFA has initially disapproved the 3.75 per cent. limitation, apparently finding the state's assurances insufficient. But we do not yet know whether this disapproval will be the final decision of HHS because the state is prosecuting

an administrative appeal within HHS from the initial disapproval of the plan. Representatives of providers of nursing-home services have intervened in this administrative proceeding in support of HCFA's initial disapproval. In this situation, we agree with the position taken by the United States as amicus curiae that the case is not yet ripe for judicial determination with respect to fiscal year 1983-84. If the initial disapproval of the 3.75 per cent. limitation with respect to this second fiscal year is ultimately upheld by HHS, we have no reason to believe that the state will not acquiesce in this decision and make payments at the proper level to the providers whom plaintiffs represent. If, on the other hand, HCFA's initial disapproval is reversed, and the 3.75 per cent. limitation is approved for the second fiscal year, the providers may return to court and pursue their claim that such approval is arbitrary, capricious, and contrary to the Boren Amendment. And, if the case does come back to court ultimately, the court may be significantly aided by whatever administrative record is compiled, as well as by the agency's reasoning. This is a complicated field, and if there is such a thing as "expertise," it is more likely to be possessed by the agency than by the courts. Accordingly, the District Court's judgment, insofar as it invalidated § 68-720 with respect to fiscal year 1983-84, will be vacated, with leave to any party aggrieved to seek relief again from the courts when the issue becomes definite and ripe.

IV.

The District Court awarded plaintiffs an attorneys' fee of $51,195.00, together with expenses of $1,078.20. Whether a fee is allowable depends on whether this suit is

properly characterized as an action under 42 U.S.C. § 1983, because, if it is, § 1988 authorizes the award of fees and expenses to the prevailing parties. The District Court disposed of this issue in plaintiffs' favor, reasoning as follows:

> . . . suits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act by participating states, *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980); *Blue v. Craig*, 505 F.2d 830, 832-33 (4th Cir. 1974), including suits by Medicaid service provides to challenge the wrongful administration of a Medicaid program by a state. *Yapalater v. Bates*, 494 F. Supp. 1349, 1357-58 (S.D.N.Y. 1980), *aff'd*, 644 F.2d 131 (2d Cir. 1981), *cert. denied*, 455 U.S. 908 (1982).

Slip op. 5.

We agree. Both the District Court and this Court have held, though for somewhat different reasons, that the state plan for the year 1982-83 is inconsistent with that portion of the Social Security Act known as the Boren Amendment. In *Maine v. Thiboutot, supra,* the Supreme Court specifically held that " 'suits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act on the part of participating states.' " 448 U.S. at 4, quoting *Edelman v. Jordan,* 415 U.S. 651, 675 (1974). The Social Security Act, including the Boren Amendment, is a "law" within the meaning of 42 U.S.C. § 1983, which creates a right of action for people who, under color of any state law, are deprived of a right secured "by the Constitution *and laws*" of the United States. "[T]he plain language of the statute undoubtedly embraces [plaintiffs'] claim that [defendants] violated the Social Security Act." 448 U.S. at 4.

The state seeks to distinguish *Thiboutot* on the ground that the plaintiffs in that case were arguably being deprived of minimal subsistence and support. Thus, the argument runs, the claim of violation of the Social Security Act in *Thiboutot* is more akin to those civil-rights statutes and constitutional provisions that have always concedely come within § 1983. We cannot agree with this distinction. It has some appeal, at least as a legislative matter, but the words of § 1983 as explicitly interpreted by the Supreme Court in *Thiboutot* are clear, and in addition, we cannot believe that Congress, without saying so, intended for the existence *vel non* of a right of action under § 1983 to depend on the wealth of the plaintiff. Moreover, the right of the long-term care institutions in this case to reimbursement under the Act could very well affect the level of care and treatment received by patients, some of whom are undoubtedly in just as much need as the plaintiffs in *Thiboutot*.

We therefore affirm the District Court's determination that plaintiffs are entitled to an award of fees and costs. The award, however, covered legal work done by counsel for plaintiffs on the entire case, and, under our disposition, plaintiffs are not yet prevailing parties with respect to the fiscal year 1983-84. We therefore believe, see *Hensley v. Eckerhart*, 461 U.S. 424 (1983), that a remand is necessary for redetermination of fees and costs. On remand, the District Court will reduce the award of fees and costs by the amount it finds reasonably attributable to work by counsel for plaintiffs with respect to the fiscal year 1983-84. We realize that this determination cannot be mathematically exact, and that much, if not most, of the work done by counsel would have been neces-

sary even if only fiscal year 1982-83 had been at issue. The District Court, in its sound discretion, will know what kind of reduction is appropriate in these circumstances. Fees were properly awarded for work pertaining to § 68-721 with respect to both fiscal years, because, defendants not having appealed any issue concerning § 68-721, the District Court's invalidation of that statute is not affected by our holding on appeal that the case is not ripe in regard to the second fiscal year.

V.

We summarize our conclusions. To the extent that it invalidated the application of § 68-720 for the fiscal year 1982-83, the judgment is affirmed. To the extent that it invalidated the application of § 68-720 for the fiscal year 1983-84, the judgment is vacated, and the cause is remanded to the District Court with instructions to dismiss the complaint, without prejudice to the right of any aggrieved party to return to court once final administrative action is complete. The award of fees and costs to counsel for plaintiffs is vacated, and the cause remanded for further consideration consistent with this opinion.

It is so ordered.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS,
EIGHTH CIRCUIT.

## APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

CV82-L-472

THE NEBRASKA HEALTH CARE ASSOCIATION, INC., et al,

Plaintiffs,

vs.

GINA DUNNING, et al,

Defendants.

MEMORANDUM AND ORDER

(Filed June 29, 1983)

The plaintiffs by filing 34 have requested leave to file a supplemental complaint to allege events occurring since the filing of the lawsuit The supplemental complaint would add Counts VI through IX. Count VI alleges that on September 22, 1982, the Department of Health and Human Services accepted certain assurances made by the state defendants and that those assurances were unreasonable and arbitrary, thus violating the plaintiffs' right to due process. Count VII alleges that since September 1, 1982, the state defendants have deprived the plaintiffs of their right to be reimbursed at rates defined by federal law and regulations, in violation of the plaintiffs' rights under the Supremacy Clause of the Constitution, thus giving a claim under 42 U.S.C. § 1983. Count VIII seeks reimbursement of the plaintiffs' costs and attorneys' fees required to obtain the injunction I issued on April 1, 1983,

and contends that the defendants' actions which necessitated the injunction have deprived and will deprive the plaintiffs of their right to reimbursement under federal statutes and law; again, the plaintiffs claim that this deprived them of their rights under the Supremacy Clause, in violation of 42 U.S.C. § 1983. Count IX alleges that the state defendants set reimbursement rates subjectively and did not provide notice of the standards to the plaintiffs, thus violating their right to due process.

The federal defendants have not objected to the plaintiffs' request to amend. The state defendants have objected to the request and moved for dismissal, filing 35. The state defendants' brief presents three arguments. They argue, first, that the allegations in the complaint do not establish this court's jurisdiction over the subject matter of the case, because the supplemental complaint asks for relief under 42 U.S.C. § 1983 but does not properly invoke the court's jurisdiction. The argument is not well taken. The original complaint cites 28 U.S.C. § 1331(a) as the jurisdictional base. Section 1331 has been amended so that neither, § 1331(a) nor the $10,000 jurisdictional minimum still exist, but the current § 1331 clearly provides for federal court jurisdiction over all civil actions arising under the Constitution or laws of the United States. Both the complaint and the supplemental complaint present claims which arise under the federal laws and Constitution.

The state defendants argue, next, that I should not allow the plaintiffs to file a supplemental complaint, because of the prejudicial effect it would have on the defendants. I see no likelihood of any effect which would be unduly prejudicial. The defendants will have ample

opportunity to present a case on all issues and will not be responsible for attorney's fees of the plaintiffs without a full exploring of the issue of whether § 1983 is applicable to the case.

The state defendants' final argument is that the plaintiffs have not stated a cause of action under § 1983, because they have not personally been deprived of any fundamental rights protected by the Fourteenth Amendment. The defendants have cited *First National Bank of Omaha v Marquette National Bank of Minneapolis*, 636 F.2d 195 (C.A. 8th Cir. 1980), for support. In that case, an Omaha bank sued a Minneapolis bank because the latter had lobbied for and obtained passage of a Minnesota statute which was later held to violate a federal banking law. The court said that 42 U.S.C. § 1983 did not create a cause of action, where a state law conflicts with the National Bank Act's provisions for the interest rate which national banks may charge on loans. The court also said that a bank's ability to charge a certain rate of interest, incidental to a broad regulatory scheme, is not in the nature of the rights protected by the Civil Rights Act, which protects basic and highly personalized human rights. *Id.*, at 198.

This argument cannot be applied to Counts VI and IX, which allege that the state defendants violated the plaintiffs' right to due process. However, it has some force in regard to Counts VII and VIII, which claim that the state defendants violated Article VI, cl. 2 of the Constitution and thereby entitled the plaintiffs to sue under 42 U.S.C. § 1983. I am not aware of any case which allows a Supremacy Clause argument to serve as the basis for a § 1983 claim, and neither party has presented any

case law on the subject and, indeed, the plaintiffs' reply brief does not even address this issue. Raising a Supremacy Clause argument in an attack on the constitutionality of a state statute is one thing, but using that argument as the sole basis for a § 1983 action is quite another. Furthermore, the *First National Bank of Omaha* case would not appear to allow such a claim; certainly the state law was struck down in favor of the federal law because of the Supremacy Clause, yet the court did not say that that allowed the plaintiff to present a § 1983 claim.

IT THEREFORE IS ORDERED:

1. That the plaintiffs' motion to file a supplemental complaint, filing 34, is granted as to Counts VI and IX only; and

2. That the state defendants' motion to dismiss, filing 35, is denied as moot.

Dated June 29, 1983.

BY THE COURT

/s/ Warren K. Urbom
Chief Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

CV82-L-472

THE NEBRASKA HEALTH CARE ASSOCIATION, INC., et al,

Plaintiffs,

vs.

GINA DUNNING, et al,

Defendants.

ORDER ON MOTION FOR RECONSIDERATION

(Filed July 22, 1983)

The plaintiffs/complainants have moved for reconsideration of the order of June 29, 1983, which denied their motion to file a supplemental complaint as to Counts VII and VIII.

I find their arguments persuasive. *Maine v Thiboutot,* 448 U.S. 1 (1980), and *Maher v Gagne,* 448 U.S. 122 (1980), are sufficient authority for the applicability of this case to 42 U.S.C. § 1983.

IT THEREFORE HEREBY IS ORDERED that the motion for reconsideration, filing 38, is granted and the complainants are given leave to file a supplemental complaint, including Counts VII and VIII, as shown in the proposed amended complaint, of which a copy is attached to the motion for leave to file supplemental complaint, filing 34.

Dated July 22, 1983.

BY THE COURT

/s/ Warren K. Urbom
Chief Judge

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

CV82-L-472

THE NEBRASKA HEALTH CARE ASSOCIATION, INC., et al,

Plaintiffs,

vs.

GINA DUNNING, et al,

Defendants.

JUDGMENT

(Filed October 10, 1984)

In accordance with the memorandum and order of July 9, 1984, filing 73, the memorandum and order of July 27, 1984, filing 76, and the memorandum regarding attorneys' fees and expenses of today, filing 80,

IT IS ORDERED that judgment is entered as follows:

1. Sections 68-720 and 68-721, R.R.S. Neb. (1982 Cum. Supp.) are declared to be unconstitutional;

2. Gina Dunning, Director of the Nebraska Department of Public Welfare; Kay Orr, Treasurer of the State of Nebraska; Clifton A. Sexton, Jr., Director of the Nebraska Department of Administrative Services, and their

agents, employees, attorneys, successors, and those persons in active participation with them, are permanently enjoined from implementing Section 6 and Section 9 of L.B. 942 of the Second Session of the Eighty-Seventh Legislature of the State of Nebraska, 1982, now codified in §§ 68-720 and 68-721, R.R.S. Neb. (1982 Cum. Supp.), and Section 1 of L.B. 618 of the First Session of the Eighty-Eighth Legislature of the State of Nebraska, 1983, now codified in § 68-720, R.R.S. Neb. 1983 Supp.); and

3. The plaintiffs are to receive from the defendants an attorneys' fee of $51,195.00 and expenses of $1,078.20.

Dated October 10, 1984.

BY THE COURT
/s/ Warren K. Urbom
Chief Judge

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

CV82-L-472

THE NEBRASKA HEALTH CARE ASSOCIATION, INC., et al,

Plaintiffs,

vs.

GINA DUNNING, et al,

Defendants.

MEMORANDUM REGARDING ATTORNEYS' FEES AND EXPENSES

(Filed October 11, 1984)

Pursuant to the memorandum and order of August 27, 1984, the plaintiffs have submitted a revised showing re-

garding attorneys' fees. I find it to be in good order and on the basis of it and the previous showing I make the following allowances:

Fee for services by—

| | |
|---|---|
| Richard P. Nelson | |
| 77 hours at $65.00 | $5,005.00 |
| 373.7 hours at $70.00 | 26,159.00 |
| William J. Morris | |
| 20.7 hours at $55.00 | 1,138.50 |
| 26.6 hours at $60.00 | 1,596.00 |
| Lavern R. Holdeman | |
| 36 hours at $50.00 | 1,800.00 |
| 1.5 hours at $60.00 | 90.00 |
| Susan L. Bowman | |
| 4.2 hours at $50.00 | 210.00 |
| 211.4 hours at $55.00 | 11,627.00 |
| Pamela J. Vuchetich | |
| 58.9 hours at $35.00 | 2,061.50 |
| law clerks | |
| 36.4 hours at $20.00 | 728.00 |

Extraordinary services preparatory to the hearing on the motion for preliminary injunction merits an enhancement of $780.00. The total fee awarded is $51,195.00.

Expenses of $1,078.20 have been requested and no objection to them has been made; they will be allowed.

The award of attorneys' fees is based upon the factors set out in *Hensley v Eckerhardt*, — U.S. —, 103 S.Ct. 1933,

51 U.S.L.W. 4522 (1983), and *Johnson v Georgia Highway Express, Inc.*, 488 F.2d 714 (C.A. 5th Cir. 1974).

Dated October 10, 1984.

BY THE COURT

/s/ Warren K. Urbom
Chief Judge

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UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

CV82-L-472

No. 84-2397

The Nebraska Health Care Association, Inc., a Nebraska Nonprofit Corporation; The Evangelical Lutheran Good Samaritan Society, a North Dakota Nonprofit Corporation; W.S.T. Care, Inc., d/b/a Crestview Care Center, a Nebraska Corporation,

Appellees,

v.

Gina Dunning, Director of the Nebraska Department of Public Welfare; Kay C. Orr, Treasurer of the State of Nebraska; Clifton A. Sexton, Jr., Director of Administrative Services,

Appellants.

On Appeal from the United States District Court
for the District of Nebraska.

(Filed March 10, 1986)

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Filed: February 25, 1986

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Before LAY, Chief Judge, ARNOLD, Circuit Judge, and REGAN,* Senior District Judge.

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We have before us the plaintiffs' petition for a panel rehearing of our opinion and order dated December 9, 1985. After due consideration of the petition, we direct that the following changes be made in our December 9, 1985 opinion:

1. On page 2 of the opinion, the portion of the second sentence of the first paragraph reading "1981-82 and 1982-83" should be changed to read "1982-83 and 1983-84."

2. The last sentence of text that begins on page 4, ("(Fiscal years for this purpose . . .") is to be deleted. In its stead insert, "It was provided that the new plan should be considered to have taken effect on August 1, 1982."

3. The following is to be inserted as a footnote to the final sentence of the paragraph on page 8:

> [5] The plaintiffs suggest that this disposition overlooks the possible effect of statutes of limitations on their rights. However, the period of limitations on the plaintiffs' claims cannot begin to run until they become ripe.

In all other respects, the petition for rehearing is denied.

a true copy.

Attest: /s/ Robert D. St. Vrain

Clerk, U.S. Court of Appeals, Eighth Circuit.

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* The Hon. John K. Regan, Senior United States District Judge for the Eastern District of Missouri, sitting by designation.

## APPENDIX C

**68-720. Certain payments to vendors; limitation on increase.** For fiscal year 1982-83, no payments shall be made by the Department of Public Welfare to any vendor for services provided to public assistance recipients, if such payments would result in a payment in excess of the fee allowed on April 1, 1982, increased by three and seventy-five hundreths per cent.

For any vendor enrolled after April 1, 1982, the initial allowable fee shall not be increased by more than three and seventy-five hundreths per cent during 1982-83.

Source: Laws 1982, LB 942, § 6.
Operative date July 1, 1982.